

PERSONS IN A COMATOSE OR VEGETATIVE STATE: INCLUDING THEM AS MENTALLY INCAPACITATED PERSONS IN THE MENTAL HEALTH ORDINANCE

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The Law Reform Commission of Hong Kong's report, released in August 2006, on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment recommends, inter alia, that the definition of a "mentally incapacitated person" in the Mental Health Ordinance be expanded to include persons who are in a coma or vegetative state. This paper examines some of the issues which the Report considers as the basis for this recommendation and the problems associated with the recommendation. The author argues that although the Report addresses some key concerns, it omits other important considerations. The author concludes with a suggestion that the issue of decision making in relation to medical treatment, and other related issues, be examined again in the near future.

Introduction

In August 2006, the Law Reform Commission of Hong Kong released a report on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment ("the Report").¹ The Report addresses the issue of "decision-making for persons who are unable to make those decisions at the time of execution of the associated action".² One dimension which the Report focuses on is proxy decision making. According to the Report, what needs to be considered are the issue relating to:

"decisions made by a third party in respect of the medical treatment and the management of *property and affairs* of persons who are comatose or in a vegetative state."³

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¹ <http://www.hkreform.gov.hk> (August 2006). This was preceded by the Law Reform Commission of Hong Kong Consultation Paper on Substitute Decision-Making and Advance Directives in Relation to Medical Treatment (<http://www.hkreform.gov.hk/en/publications/rdecision.htm>) (July 2004).

² The Report, Preface, para 3.

³ *Ibid*, emphasis added.

The Report recommends, *inter alia*, that the definition of a “mentally incapacitated person” (MIP) in the Mental Health Ordinance (MHO) be expanded to include persons who are in a coma or vegetative state.⁴

In this article, the term “adult lacking capacity” refers to one who cannot make decisions required to be made, “mentally incapacitated person” is used only in the context of the MHO because it is a statutorily defined term, and the terms “decision making” or “proxy decision making” refer only to *medical decisions*, and not to decisions relating to the management of *property and affairs*.⁵ The reason for this distinction is that the Report is entitled “...Decision-Making...in Relation to Medical Treatment”; decision making concerning the management of property and affairs, as a result, is strictly beyond its scope.

This article is divided into four parts. First, it outlines – what the Report acknowledges as important – the law governing decision making in view of Hong Kong’s aging population. The author comments, however, that the Report does not go into sufficient depth in considering the legal difficulties associated with decision making in respect of medical treatment of the elderly, and that it instead focuses on a sub-group of adults lacking capacity, ie those in a coma or vegetative state. Part 2 examines the common law principles governing medical treatment for adults lacking capacity. In Part 3 the author identifies the inadequacies of the common law: primarily, that there is no possibility of proxy decision making by a relative or guardian (Part VIC of the MHO currently provides a statutory mechanism for proxy decision making, but the current definition of a MIP in the MHO does not cover those who are in a coma or vegetative state). Part 4 examines the Report’s recommendation that the definition of a MIP be expanded to include those patients who are in a coma or vegetative state, thereby allowing proxy decision making in such cases. The paper concludes with an examination of the problems associated with this recommendation.

The author submits that the Report has made an excellent start, but that it omits some important considerations. The author, therefore recommends that decision making in relation to medical treatment, and other related issues, be examined again in the near future.

⁴ Recommendations 10 and 11; see also Ian Stoker, “Substitute Decision-Making and Advance Directives in Relation to Medical Treatment” (2006) *Hong Kong Lawyer* 26–28.

⁵ Paragraph 3 (quoted above), emphasis added. The phrase “property and affairs” in Part II of the MHO does not extend to making decisions regarding medical treatment. Medical decisions are personal in nature and do not relate to “property and affairs”, see *Re W* [1970] 1 All ER 502. See also Peter Bartlett and Ralph Sandland, *Mental Health Law: Policy and Practice* (London: Blackstone Press Limited, 2000), p 399.

1. Decision Making and Hong Kong's Aging Population

The Report begins with the legal importance of decision making:

“Making decisions is an important part of life. It empowers people by allowing them to express their individuality. It enables people to control their lives and gives them a sense of self-respect and dignity. However, for some decisions to be legally effective, it is necessary that the person making the decision has a certain level of understanding. The reason for this is very simple: it is to protect against abuse or exploitation of a person who may be made vulnerable by impaired decision-making capacity. It also helps other people who may be affected by a decision to know where they stand.”⁶

The Report presents the context in which decision making is likely to be of increasing importance, particularly in light of Hong Kong's changing demographics. The Report says:

“In line with global trends, Hong Kong's population is rapidly aging. The 1999 report noted that the number of those aged 65 or above in 1981 was 334,000, and this elderly population had increased to 690,000 by 1998. This figure was said to represent 11% of the total population....The 1999 report also projected that by 2016, the number of elderly persons in the population would reach 1,080,000, amounting to about 13% of the total population.”⁷

The rapidly aging population will exert an enormous pressure on social and healthcare services, for example a growing demand for various forms of elderly care.⁸ Furthermore, a question of increasing importance is: who is legally authorised to make decisions for those who are incapable of doing so themselves? As the Report says:

“The legal problems that stem from health care and medical treatment of the elderly will inevitably arise, particularly when they are, or are becoming, mentally incapacitated by reason of illness or physical injury.”⁹

⁶ Paragraph 1.

⁷ Paragraph 1.10.

⁸ Chu and Chi, “Long-term care and hospital care for the elderly” in Leung and Bacon-Shone (eds) *Hong Kong Health System: Reflections, Perspectives and Visions* (Hong Kong University Press, 2006), pp 223–252.

⁹ Paragraph 1.12.

One problem of particular concern is dementia. Available statistics indicate that the incidence of dementia is five to 10 per cent in persons over 65, and 20 per cent in persons over 80.¹⁰ Some patients have been shown to survive up to 15 years from the point of diagnosis with the average survival being eight to 10 years. As the Report notes:

“the typical clinical course in dementia is progressive decline in mental and physical functions, leading to total dependence on others and requiring multiple levels of services.”¹¹

In view of the above, one possible option for handling the need for decision-making of an elderly person suffering from a progressively degenerative disease (such as dementia) is proxy decision making.

Although the Report commences with a discussion on the elderly, it does not contain much analysis on the legal problems associated with the decision-making process of, or proxy decision making for, the elderly. This is because the Report narrows its focus on a sub-group of adults lacking capacity, that is, those who are in a coma or vegetative state (even though this sub-group is not generally associated with the elderly).¹² It is unclear in the Report why this focus is adopted. The Report also does not provide an estimated population of this sub-group in Hong Kong. It is submitted that the legal problems of those in a coma or vegetative state overlap in many respects with those of demented elderly persons lacking decision making capacity, yet such a narrow focus appears to reduce the importance of the Report's recommendations.¹³ Nonetheless the Report thoroughly outlines the general principles governing adults lacking capacity.

2. The Common Law Governing Medical Treatment for Adults Lacking Capacity

The Report outlines the common law position in Chapter 4 “Mentally incapacitated persons: the common law and consent to medical treatment”. It correctly summarises, *inter alia*, the principles of consent, self-determination, sanctity of life (and where a patient is competent, sanctity of life must

¹⁰ Paragraph 1.6.

¹¹ Paragraph 1.7.

¹² The Report notes that the cause of coma is usually unrelated to aging. It states that coma “is usually as the result of a head injury, neurological disease, acute hydrocephaly, intoxication or metabolic derangement”, see para 6.8.

¹³ In Part 4 of this article, it is submitted however that the impact of the Report's recommendation is actually much wider.

yield to self-determination) and the doctrine of necessity.¹⁴ These principles will be restated only if they are relevant here.

2.1 Right to self-determination of a competent adult

A general common law principle is that medical treatment of a competent adult is unlawful unless it is given with that person's valid consent.

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault ..."¹⁵

The rationale for this is that a competent adult has the right to self-determination, and may refuse beneficial treatment. Effectively, what may be considered as a medical benefit may not be imposed on a person without his or her consent.

2.2 No proxy consent

In the case where an adult has been rendered unconscious in a traffic accident, it is reasonable to think that a relative's consent would be required before treatment could lawfully proceed. Contrary to common belief, the common law does not recognise proxy consent for medical treatment in such cases. The practice of seeking the consent of a relative prior to treatment in such circumstances is a misconception, as a relative has no legal right either to consent or to refuse. In fact, no one has such a right. In *Re T (Adult: Refusal of Treatment)*,¹⁶ Lord Donaldson said:

"There seems to be a view in the medical profession that in ... emergency circumstances, the next of kin should be asked to consent on behalf of the patient and that, if possible, treatment should be postponed until that consent has been obtained. This is a misconception because the next of kin has no legal right whether to consent or to refuse consent."

2.3 Doctrine of necessity: treatment for the best interests of adults lacking capacity

The common law governing the lawfulness of a treatment given to an incapacitated adult (for instance, an adult who has been rendered unconscious in a traffic accident) was considered by the English House of Lords'

¹⁴ Paragraph 4.49.

¹⁵ *Schloendorff v Society of New York Hospital* (1914) 211 NY 125.

¹⁶ [1992] 4 All ER 649 at p 653.

decision in 1989 in *Re F (Mental Patient: Sterilisation)*¹⁷ (hereafter *Re F*). In *Re F*, the House of Lords was confronted with F, a 36-year-old sexually active mentally disabled woman with the verbal capacity of a two-year-old. Medical evidence suggested that she would be unable to cope with pregnancy, delivery and childbirth. All contraceptive methods, other than sterilisation, were thought to be inappropriate. As a consequence, sterilisation was considered to be in her best interests but she was unable to give a valid consent. The patient's mother sought a judicial declaration that the proposed sterilisation should be lawful despite F's inability to give a valid consent.

It was held that a doctor may lawfully treat such a patient without consent if the treatment is in the best interests of the patient. A treatment is deemed to be in the best interests of a patient if it saves a life, or if it ensures improvement or prevents deterioration in a patient's physical or mental health. Further, whether a treatment is in the best interests of a patient depends on what is accepted as appropriate by a responsible body of medical opinion in that particular treatment. It follows, therefore, that the legality of treatment given to an incapacitated patient is not premised on the court's approval, and that medical care can be delivered efficiently without delay.

2.4 Judicial declaration as a means of protecting adults lacking capacity

The Report notes that *Re F* confers on doctors the power over the incapacitated patients on the basis of "doctor knows best".¹⁸ It also notes the usefulness of judicial declaration.¹⁹ However, it does not consider how the common law has adapted itself for the protection of adults lacking capacity who are vulnerable under this "doctor knows best" approach, especially in the context of some controversial and irreversible decisions (for instance, withdrawing of life-sustaining treatment of a person who is in a coma or vegetative state).²⁰

The protective mechanism introduced by the House of Lords in *Re F* was that non-therapeutic sterilisation of an incapacitated person should be placed in a special category. This means that, as a matter of good practice, although not strictly necessary, such an operation should be brought before the court for an independent, objective and authoritative review on the lawfulness of the procedure.²¹ The decision in *Re F* is now reflected in Part

¹⁷ [1989] 2 All ER 545.

¹⁸ Paragraph 6.29.

¹⁹ Paragraph 6.35.

²⁰ *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

²¹ For developments since *Re F*, see *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2001] 2 FLR 158.

IVC of the MHO. Part IVC of the MHO provides a statutory mechanism for proxy decision making; and it has made non-therapeutic sterilisation a “special” treatment. This means that consent of a relative or guardian *per se* would not render the operation lawful. Effectively, non-therapeutic sterilisation may only be performed with judicial consent.²²

3. Problem Addressed by the Report: a Person in a Coma or Vegetative State

The general principles mentioned above (in *Re F*) apply to all adults lacking capacity irrespective of the reasons for their incapacity (ie whether it is as a consequence of aging or from an accidental injury resulting in a coma or vegetative state).

The Report focuses its attention on those who are comatose or in a vegetative state; both conditions that are usually unrelated to aging.

The Report defines these two terms in the context of a much larger medical condition. This much larger medical condition is defined in the Report in four stages (or medical condition): coma, vegetative state, continuing vegetative state and permanent vegetative state. In layman’s terms, they represent a continuum of progressive irreversibility of a hopeless condition. What is important to point out here is that, legally, a person in any of these four states is not dead.²³ The Report defines coma as follows:

“Coma is defined as a prolonged state of unconsciousness...When persons experience a brain injury, they can lose consciousness. When the unconscious state is prolonged, it is termed a ‘coma’. A coma is a continued unconscious state that can occur as *part of the natural recovery* for a person who has experienced a severe brain injury...Persons who sustain a severe brain injury and experience coma can *make significant improvements*, but are often left with permanent physical, cognitive or behavioural impairments...The length of a coma cannot be accurately predicted or known.”²⁴

A vegetative state is defined as:

“A clinical condition of unawareness of self and environment in which

²² Section 59ZG. See also Liu, “Consent to medical treatment for and by a mentally incapacitated adult: the interplay between the Hong Kong common law and Part IVC of the Mental Health Ordinance (MHO)”, *Law Lectures for Practitioners* (Hong Kong: Sweet & Maxwell Asia, 2005).

²³ *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

²⁴ Paragraph 1.14, emphasis added.

the patient breathes spontaneously, has a stable circulation and shows cycles of eye closure and eye opening which may simulate sleep and waking. This may be *a transient stage in the recovery* from coma or it may persist until death.”²⁵

Unlike a person who is in a coma or vegetative state, a person who is in a continuing vegetative state or permanent vegetative state means that recovery is increasingly unlikely. A continuing vegetative state (CVS) is defined as:

“When the vegetative state continues for *more than four weeks* it becomes increasingly unlikely that the condition is part of a recovery phase from coma and the diagnosis of a continuing vegetative state can be made.”²⁶

A permanent vegetative state (PVS) is defined as:

“A patient in a continuing vegetative state will enter a permanent vegetative state when the diagnosis of *irreversibility* can be established with a high degree of clinical certainty. It is a diagnosis which is not absolute but based on probabilities. Nevertheless, it may reasonably be made when a patient has been in a continuing vegetative state following head injury for *more than 12 months or following other causes of brain damage for more than six months*.”²⁷

In light of these definitions, one can see that the Report considers only the position of those who are in the first two stages (ie those who are in a coma or vegetative state); and it recommends that such patients be included within the definition of a MIP in the MHO.

The reason for the Report’s recommendation appears in Chapter 6, under “Deficiencies in the Mental Health Ordinance”. The Report notes that the current definition of a MIP in the MHO is limited to those who are mentally disordered and mentally handicapped.²⁸ The MHO currently defines “mental disorder” to mean:

²⁵ Paragraph 1.15, emphasis added.

²⁶ Paragraph 1.15, emphasis added.

²⁷ Paragraph 1.15, emphasis added.

²⁸ Section 2 defines “mental handicap” to mean “sub-average general intellectual functioning with deficiencies in adaptive behaviour”. It further defines “sub-average general intellectual functioning” to mean “an IQ of 70 or below according to the Wechsler Intelligence Scales for Children or an equivalent scale in a standardized intelligence test”.

- “(a) mental illness;
- (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;
- (c) psychopathic disorder; or
- (d) any other disorder or disability of mind which does not amount to mental handicap.”

The Report outlines the problem with the existing legislation:

“Clearly, a person in a coma or ‘vegetative state’ does not fall within category (b) or (c) of the Cap 136 definition of ‘mental disorder’ as he obviously cannot exhibit *‘aggressive or seriously irresponsible conduct.’* It is also doubtful that he would fall within category (a) of the definition as the exact meaning of the term ‘mental illness’ is far from clear... Whether a ‘vegetative’ patient or a person in coma would fall within category (d) (*‘any other disorder or disability of mind which does not amount to mental handicap’*) is again unclear.”²⁹

In short, those who are in a coma or vegetative state do not clearly fall within the current legal definition of a MIP of the MHO.

To the uninitiated, the obvious question is: why should a person who is in a coma or vegetative state be within the MHO? After all, the MHO has often been associated with those who are mentally disordered or handicapped. Furthermore, as explained in Part 2 above, the decision making process for these patients in relation to medical treatment is now governed by the common law principles in *Re F*.

The Report considers the common law on this issue to be problematic. It states that:

“The existing legal mechanisms are complicated, inflexible and piecemeal. The establishment of the Guardianship Board under the Mental Health Ordinance has made some improvements to the Ordinance in promoting the welfare and care of the mentally incapacitated ...”³⁰

It is submitted that there are various reasons why the existing common law, with no provision for proxy decision making, may be considered inadequate. The first three relate to the doctrine of necessity (as outlined in Part 2 of

²⁹ Paragraphs 6.6–6.7; see also para 6.21.

³⁰ Paragraphs 6.44–6.46.

this article) and the last is cultural. First, it could be argued that the doctrine of necessity gives too much power to doctors to provide treatment in what they consider to be in the best interest of the patients. Secondly, the best interests of a patient as viewed by a doctor may differ from the view of the patient's or the patient's family. Thirdly, the exact scope of the doctrine of necessity may be uncertain (as can be seen in recent case law).³¹ Fourthly (and this may be the most important), Hong Kong is a predominantly Chinese society which stresses family relationships. An adult lacking capacity is often cared for and supported by family members. It therefore may appear odd, if not unreasonable, that family members cannot make decisions for, and on behalf of, their dependant adult. Many may also argue that in view of the relatively strong family ties, family members may actually know what the patient would consider to be acceptable medical treatment. Consequently, there is no reason why a doctor (who is likely to be a stranger to the patient and the family) should decide.

In light of the reasons above, it is submitted that there is a clear need for proxy decision making. The importance of proxy decision making is noted by the Report, again in the context of the aging population. As the Report states,

"The problem of proxy decisions is present almost daily and with an aging population its incidence can be expected to increase. It may therefore be necessary to put in place a mechanism which facilitates the decision-making process and to ensure that this mechanism articulates the rights and duties of those affected."³²

Proxy decision making is currently not possible under common law. However, it is available under Part IVC of the MHO.³³ One obvious solution which can overcome the inadequacies of the common law is to expand the definition of a MIP so that proxy decision making is made available to those who are in a coma or vegetative state.

³¹ On the limits of the doctrine of necessity, see *HL v United Kingdom* (45508/99) (2005) 40 EHRR 32 (ECHR).

³² Paragraph 6.39.

³³ The statutory provisions governing proxy decision making of an MIP can be found in Part IVB and Part IVC of the MHO. Part IVB establishes the Guardianship Board. The Guardianship Board has the power to appoint a guardian for an MIP, and the guardian may be given the power, *inter alia*, to consent to treatment on behalf of an MIP. Part IVC stipulates the rules governing consent to medical and dental treatment. It envisages two types of proxy consent, these are proxy consent to treatment given by a guardian, and consent given by the court on behalf of a MIP. Part IVC applies only if an MIP is "incapable of understanding the general nature and effect of a treatment", and hence is unable to give valid consent. See Liu, "Consent to medical treatment by or for a mentally incapacitated adult: the Hong Kong common law and Part IVC of the Mental Health Ordinance" 1 *Asian Journal of Gerontology & Geriatrics* (2006) 31.

4. Expanding the Definition of an MIP in the Mental Health Ordinance

The Report, therefore, recommends that the definition of a MIP be expanded to cover a person in a coma or vegetative state. Recommendation 10 states:

“the definition of ‘mentally incapacitated person’ ... should be amended along the following lines:

- (1) ... a mentally incapacitated person is a person who is at the material time –
 - (a) unable by reason of mental disability to make a decision for himself on the matter in question; or
 - (b) unable to communicate his decision on that matter because he is unconscious or for any other reason.
- (2) For the purposes of subsection (1), a person is at the material time unable by reason of mental disability to make a decision if, at the time when the decision needs to be made, he is –
 - (a) unable to understand or retain the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another or of failing to make the decision; or
 - (b) unable to make a decision based on that information.
- (3) In subsection (1), ‘mental disability’ means –
 - (a) mental illness;
 - (b) a state of arrested or incomplete development of mind which amounts to a significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned;
 - (c) psychopathic disorder;
 - (d) mental handicap; or
 - (e) any other disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.
- (4) A person shall not be regarded as unable to understand the information referred to in subsection (2)(a) if he is able to understand an explanation of that information in broad terms and in simple language.

- (5) A person shall not be regarded as unable by reason of mental disability to make a decision only because he makes a decision which would not have been made by a person of ordinary prudence.
- (6) A person shall not be regarded as unable to communicate his decision unless all practicable steps to enable him to do so have been taken without success."

Readers will note that this expanded definition covers not only those who are mentally ill and handicapped (as is the case with the current definition); it also covers any adult who is unable to make a decision by reasons of mental disability or who is unable to communicate a decision. This effectively covers not only the demented, stroke patients and brain injured patients, but also those who are in a coma or vegetative state. Such a definition would assist those in need; however, what should have been made clear by the Report is that this recommendation covers many more patients than those who are in a coma or vegetative state.

5. Conclusion

Statistics on the elderly population are outlined early in the Report; statistics that portray a picture in which many demented elderly persons will lack the capacity at one time or another to make decisions. This may be misleading if the focus of the Report is only concerned with those in a coma or vegetative state. Yet, as discussed above in Part 4 of this paper, its recommendation in fact applies to all who are unable by reasons of mental disability to make decisions, or to communicate a decision. Even if one confines the Report's recommendation to those who are in a coma or vegetative state, the recommendation does not explore a potential conflict between proxy decision making under the MHO and the common law. As the author has already discussed this issue in another paper, it will not be elaborated upon here.³⁴

Another problem with the recommendation, if implemented, is that the MHO may be overworked. This is because it will cover not only adults lacking capacity (such as the demented elderly, stroke victims and those who are comatose or in a vegetative state) on the one hand, but also those who are mentally ill and handicapped, on the other hand. These two groups

³⁴ Liu, "Consent to medical treatment for and by a mentally incapacitated adult: the interplay between the Hong Kong common law and Part IVC of the Mental Health Ordinance (MHO)", *Law Lectures for Practitioners* (Hong Kong: Sweet & Maxwell Asia, 2005).

share one common characteristic: they need long-term care and guardianship. The Report's recommendation effectively brings them all under the MHO.

To avoid overworking the MHO with complex categories of vulnerable people, it is submitted that it may be preferable to deal with these two groups of patients in separate ordinances.³⁵ Thus, those who are mentally ill or handicapped (currently governed by the MHO), requiring compulsory treatment and confinement to prevent them from harming themselves and others, would continue to be governed by the MHO. However patients who are not likely to cause danger to themselves and others, but merely require care and attention, should be covered by a new Adult Guardianship Ordinance (as opposed to the existing Guardianship of Minors Ordinance).

As regards the elderly population, many of whom may suffer from dementia, the legal issues arising from medical decision making, or decision making generally, require further examination. It is submitted that the Law Reform Commission should, despite the work of the Elderly Commission,³⁶ examine the adequacy of existing legal protection. Currently, most of the elderly are cared for by their relatives, at hostels, care and attention homes or infirmaries depending on their needs, and the majority are without any guardianship order.³⁷ Those working in care institutions know, it is common practice that many elderly are tied to their chairs (by restrainers), and some care workers believe that they are authorised to use such restrainers because the patients' relatives have signed a consent form. A newspaper recently reported³⁸ that some of these care establishments routinely deduct all social welfare money from their elderly resident-clients, leaving them with no day-to-day pocket money, while other elderly people are victims of both physical and financial abuse.³⁹ All these raise questions beyond medical decision making and highlight elderly dependency and their need for legal protection. The Hong Kong Law Reform Commission should examine these issues as a matter of urgency.

As regards mental health law, the MHO is also due for a thorough review. This is so because the MHO was enacted in 1960, and since then it has been amended, on an ad hoc basis, more than 20 times. One review

³⁵ However, the distinction between mental health issues and non-mental health issues may not always be clear in some cases. See, eg, *B v Croydon District Health Authority* [1994] 22 BMLR 13; *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762. See also Bartlett and Sandland, *Mental Health Law: Policy and Practice* (London: Blackstone Press Limited, 2000), pp 220–223.

³⁶ *Report of the Elderly Commission 1997–1999*. (<http://www.elderlycommission.gov.hk/en/library/ECREPORT.HTM>) (accessed on 17 Nov 2006).

³⁷ See *The Guardianship Board First Report 1999–2001*, for the numbers of orders made at p 33. See also *The Guardianship Board Second Report 2003–2006*.

³⁸ Ming Pao, 7 Nov 2005.

³⁹ Sing Pao, 12 June 2006; *Re Madam L* [2004] HKEC 1269.

agenda would be to consider whether the admission of a demented person for treatment under the MHO complies with the existing human rights provisions in Hong Kong.⁴⁰

⁴⁰ “‘Bournewood’ Consultation: the approach to be taken in response to the judgment of the European Court of Human Rights in the ‘Bournewood’ case”, DoH, March 2005; “Bournewood Briefing Sheet”, DoH, June 2006 (<http://www.dh.gov.uk/PublicationsAndStatistics>).